

State/Territory: WISCONSIN

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

OFFICIAL

c. Intermediate care facility services.

☒ Provided: ☐ No limitations ☒ With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*

- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☐ No limitations ☒ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 90-32

Supersedes

TN No. 88-17

Approval Date 1-24-91

Effective Date 10/1/90

HCFA ID: 0140P/0102A

State/Territory: WISCONSIN

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations*

___ Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

X Provided: X With limitations*

___ Not provided.

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

X Provided:+ X Additional coverage**

- b. Services for any other medical conditions that may complicate pregnancy.

X Provided:+ X Additional coverage** ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

TN No. 95-019
Supersedes
TN No. 94-025

Approval Date OCT 23 1995

Effective Date _____

State/Territory: WISCONSIN

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided. Eff. 8-9-89

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*

c. Care and services provided in Christian Science sanatoria.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

e. Emergency hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*

TN No. 90-0027
Supersedes
TN No. 89-0021

Approval Date 11-5-90

Effective Date 7-1-90

HCFA ID: 1042P/0016P

State/Territory: WISCONSIN

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

-
24. Pediatric nurse practitioner and family nurse practitioner services.
Effective 7-1-90.

☒ Provided: ☐ No limitations ☒ With limitations*

25. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

☒ Provided: ☐ No limitations ☒ With limitations

TN No. 90-0032
Supersedes
TN No. ~~89-0021~~
90-27

Approval Date 1-24-91

Effective Date 10/1/90

HCFA ID: 1042P/0016P

State/Territory: WISCONSIN

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

X Provided Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided: State Approved (Not Physician) Service Plan Allowed

 Services Outside the Home Also Allowed

X Limitations Described on Attachment

 Not provided.

State Wisconsin

Attachment 3.1-B

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AMOUNT, DURATION AND SCOPE OF SERVICES

MEDICALLY NEEDY GROUP(s): All

-
- a. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.
- ☒ Provided
- ☐ No limitations
- ☒ With limitations*
16. Inpatient psychiatric facility services for individuals under 22.
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*
17. Nurse-midwife services.
- ☒ Provided
- ☐ No limitations
- ☒ With limitations*
18. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- ☒ Provided
- ☐ No limitations
- ☒ With limitations*
- a. Transportation
- ☒ Provided
- ☐ No limitations
- ☒ With limitations*
- b. Services of Christian Science Nurses.
- ☐ Provided
- ☐ No limitations
- ☐ With limitations*

*Description provided on attachment.

TN # _____

Supersedes _____

TN # _____

Approval Date _____

Effective Date 3-1-86

Supersedes _____

Date Appr. 5/19/86

State Rep. In _____

Date Eff. 3/1/86

State Wisconsin

AMOUNT, DURATION AND SCOPE OF SERVICES

MEDICALLY NEEDY GROUP(s): All

- c. Care and services provided in
Christian Science sanatoria.

☒ Provided
☐ No limitations
☒ With limitations*

- d. Skilled nursing facility
services provided for patients
under 21 years of age.

☒ Provided
☐ No limitations
☒ With limitations*

- e. Emergency hospital services in
recipient's home, prescribed
in accordance with a plan of
treatment and furnished by a
qualified person under supervision
of an R.N.

☐ Provided
☐ No limitations
☐ With limitations*

- f. Personal care services in recipient's
home, prescribed in accordance with
a plan of treatment and furnished
by a qualified person under supervision
of an R.N.

☒ Provided
☐ No limitations
☒ With limitations*

*Description provided on attachment.

TN # _____
Supersedes
TN # _____

Approval Date _____

Effective Date 3-1-86

File # 86-003 Date Rec'd 4/1/86
Supercodes 82-096 Date Appr. 5/9/86
State Rep. In. _____ Date Eff. 3/1/86

State Wisconsin

Attachment 3.1-B

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): All

17. Nurse-midwife services.

☒ Provided☒ No limitations☐ With limitations*

18. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation

☒ Provided☐ No limitations☒ With limitations*

b. Services of Christian Science Nurses

☐ Provided☐ No limitations☐ With limitations*

c. Care and services provided in Christian Science sanatoria

☒ Provided☐ No limitations☒ With limitations*

* Description provided on attachment.

TN # 82-90
Supersedes
TN # _____Approval Date 12-16-82Effective Date 11/1/82
11-1-81

State Wisconsin

Attachment 3.1-B
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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): All

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- | | |
|---|--|
| d. Skilled nursing facility services provided for patients under 21 years of age. | <input checked="" type="checkbox"/> Provided
<input type="checkbox"/> No limitations
<input checked="" type="checkbox"/> With limitations* |
| e. Emergency hospital services | <input type="checkbox"/> Provided
<input type="checkbox"/> No limitations
<input type="checkbox"/> With limitations* |
| f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of an R.N. | <input checked="" type="checkbox"/> Provided
<input type="checkbox"/> No limitations
<input checked="" type="checkbox"/> With limitations* |

* Description provided on attachment.

TN # 82-90
Supersedes
TN # _____

Approval Date 12-16-80 Effective Date 11/1/81

Attachment 3.1B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Wisconsin

METHODS OF PROVIDING TRANSPORTATION

The methods used in providing transportation services (which may include cost of outside meals enroute to and returning from a medical facility and of an attendant if not a member of the patient's family), are as follows:

1. Medical vendor payments are available to ambulance services providers for emergency and non-emergency services provided in accordance with HSS 107.23 of Wisconsin Administrative Code, and when the provider is certified pursuant to HSS 105.38, Wis. Adm. Code.
2. Medical vendor payments are also available to specialized medical vehicles (e.g., handicabs) and other transportation providers for non-emergency services provided to recipients who have a physician's order or who are confined to a wheelchair for transportation to medical services. (See HSS 107.23, Wis. Adm. Code)
3. A Medical Assistance administrative payment may be made for transportation by public carrier, private automobile, relatives, friends, etc. to obtain medical care, unless these services are provided under 4 below. Such payment requires advance authorization by the appropriate county department of social services prior to the medical transportation.
4. A Social Service administrative payment is made for the same services as listed in items 1 and 2 above, if provision of the services is a part of comprehensive social service plan.

HCFA-179 # 56-0005 Date Rec'd 4/1/86
Supersedes 82-0094 Date Appr. 11/25/86
3/1/86